Supplemental Payments Reimbursement Request

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
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http://www.dwd.state.wi.us/wc/
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The provision of your social security number is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

To: Department of Workforce Development, Worker's Compensation Division

Request is made for reimbursement of supplemental benefits paid during the preceding calendar year under the provisions of s.102.44(1), Wisconsin Statutes, in the following cases and in the amounts indicated.

List alphabetically by injured employee names.

Name	Social Security Number	Employer	Injury Date	Weekly Supplemental Rate	Begin Date	End Date	Number of Weeks and Days	Amount of Reimbursement Requested
								Total: $

I certify that the above amounts requested for reimbursement are true and correct and they were paid during the preceding calendar year.

Name of Carrier or Exempt Employer to Whom Check Should be Mailed	Mailing Address (Number, Street, City, State, Zip Code)	
Signed by	Title	Date Signed
FEIN Number	Telephone Number	

Please forward original and one copy to the return address shown at the top of this form.

WKC-140 (R. 07/2001)